Delivery of mental health services in rural areas is a serious problem. A project to develop and assess a particular pattern of rural mental health services was started in two North Carolina counties. As part of this project a survey was made of the attitudes and opinions of rural people concerning mental illness, mental health professionals, and related services. The results are reported in this paper.

ATTITUDES AND OPINIONS OF RURAL PEOPLE ABOUT MENTAL ILLNESS AND PROGRAM SERVICES

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Introduction

MENTAL health program personnel have for many years attempted to find solutions to the problem of delivery of mental health services to rural communities. Mobile clinic teams have been tried with relatively little lasting success and, indeed, have helped to prove that other than traditional clinic approaches are mandatory. Attempts have been made to utilize other professionals in rural communities to help with the mental health job. These have included public health nurses,[1-3] local welfare workers, and, from time to time, members of the agricultural extension services. Single professionals have been deployed in given areas to provide consultation, referral, educational, and case services. Examples of this are the mental health worker program of Florida[4] and the community consultant approach in New Mexico[5] and Wisconsin.[6] These workers also provide leadership for the development of indigenous mental health programs tailored to local needs, resources, and political processes.

It seems obvious that some means must be found that will utilize the manpower from all the human services programs that exist in rural areas, as scarce as they are in comparison with their urban and better financed counterparts. It seems equally obvious that the need for mental health services in rural areas will be with us for some time to come. In spite of the rapid urbanization and coincident decline in rural population, it is still a fact that 30 per cent of our total population lives outside the boundaries of our urban places. In North Carolina alone, 34 of the 100 counties have no urban places (2,500 people or more) as defined in the 1960 census, which means these counties are 100 per cent rural. Eighty-nine of the 100 counties had more rural than urban population in 1960.

In the face of this and similar circumstances in vast stretches of this country we in the Community Psychiatry Section of the Department of Psychiatry at the University of North Carolina have initiated a project designed to develop, evaluate, and assess the feasibility of a pattern of rural mental health services which might also have application in other rural areas in the country.

Among the strategies employed to test

the effectiveness of the mental health program, our research team undertook a survey to assess the information, attitudes, and opinions presently held by community people about mental illness, some mental health professionals, and program services. Following a five-year period of program development, it is expected that a similar assessment of the same cohort will take place for purposes of a "before-after" comparison.

Method

An area sampling technique[7] was employed to secure a random sample of 960 respondents ages 20-70 who lived in two predominantly rural North Carolina counties. A structured interview schedule containing 157 items was used in gathering the basic data. This interview schedule (i.e., questionnaire) was designed to elicit the following information and opinions to be reported here:

1. Background data such as age, race, sex, occupational, education, and marital status of the respondent.
2. The level of awareness of mental health services or projects in the community.
3. Statements as to the mental health resources and services needed to deal with problems of mental illness.
4. The attitudes of the respondents toward mental illness, the mentally ill, and mental health professionals.
5. The extent of social distance from the mentally ill, and feelings of social responsibility for the mental illness in the community.

A great many items which have been used in other studies were incorporated into the questionnaire. By following this procedure some interesting and fruitful comparisons with the results of other investigations can be made; and, because most of the previous research in this area has focused primarily upon urban samples, a study of a rural population will, hopefully, add a new dimension and provide some additional insights into public opinions and knowledge about mental illness.

Standard interviews lasting 45 to 90 minutes were conducted by trained interviewers, usually in the home of the respondent. Interviews were obtained from 97 per cent of all those who were eligible for the sample.

Description of the Sample

The sample can be generally described as a rural, poorly educated, low socioeconomic farming population. Two-fifths of the sample have family incomes falling below the currently established poverty level of $3,000. The median family income is less than $4,000. In education, nearly one-quarter (22.8 per cent) of our respondents have had less than seven years of formal schooling. An additional 28 per cent have not gone beyond the ninth grade. One-quarter are high school graduates; 4 per cent have graduated from college, and some of these also have professional training.

A census-matching proportional number of whites and nonwhites of both sexes in the age group of 20 to 70 were included in the sample. The median age is 46 years. Thirty-two per cent of the respondents are classified as urban and the remaining 68 per cent fall into he rural category. The occupations of the respondents range from managers of large business firms to those on welfare. Unskilled farm labor constitutes the largest category of workers (20.9 per cent).

Seventy per cent of the sample have spent most of their lives in a rural setting, while 28 per cent have lived principally in small towns. Only about 1 per cent of the respondents have lived mainly in a "big city" atmosphere during their lifetimes.

The sample as a whole is highly stable in terms of geographic mobility. Over three-quarters of the respondents have lived in their respective counties for 20 or more years. The median stay is upward of 35 years. Only about 13 per

Table 1—Kinds of mental health services and facilities needed to deal with task of *preventing* mental illness in the community

	No.	%
Mental health clinic	76	7.9
Mental hospital	24	2.5
Recreation	38	4.0
Special schools for the retarded	16	1.7
Guidance and counseling center	14	1.5
Information center	17	1.8
Other—churches, A.A., etc.	21	2.2
Something needed, but not specified	292	30.3
Nothing needed	13	1.4
Don't know/No answer	449	46.5
Total	960	100.0

cent of those surveyed reported that they have resided in the county for ten years or less.

Awareness of Resources

Both of the project counties have a serious limitation in mental health resources within their borders. In one of the counties, a part-time mental health clinic offers minimal clinical services. In addition, that county has an active Alcoholics Anonymous group and a "struggling" mental retardation program. The other experimental county is without any formal mental health services or facilities.

Given these conditions, and the minimal availability of the clinic and Alcoholics Anonymous (AA), it is not at all surprising that 94 per cent of the respondents were unaware of the existence of any mental health services or facilities in the community. It should be mentioned, however, that those who knew of the clinic, AA, and special classes for the retarded, expressed highest approval for these programs.

Noting that the communities have either minimal or no mental health services, facilities, or professionals, we attempted to find out which of these was felt would be necessary to prevent and treat mental illness in the community. The respondents had a difficult time differentiating between those services and facilities focusing on treatment and those aimed primarily at prevention. In either case, less than 2.0 per cent felt that no facilities at all were needed. Similarly, in response to the two questions, approximately one-half of the sample did not know what services would be most desirable for the treatment and prevention of mental illness. In the case of prevention (see Table 1) about one-third of the people interviewed expressed the feeling that something was needed, but could not specify what it was. Fourteen per cent felt this same way with respect to the treatment question (see Table 2). A mental health clinic was mentioned as the most needed resource for treatment and prevention of mental illness. Nonpsychiatric physicians and psychiatrists are viewed as the two professional groups most needed to help solve the problem of mental illness; other professionals were mentioned, but not to any great extent (see Table 3).

In recent years, the idea of a comprehensive mental health center program

Table 2—Kinds of mental health services and facilities needed to deal with problems of *treating* mental illness in the community

	No.	%
Mental health clinic	163	17.0
Mental hospital	86	9.0
Alcoholics Anonymous	4	0.4
Special school for the retarded	44	4.6
Guidance and counseling center	10	1.0
Mental health information center	3	0.3
Other—churches, recreation, etc.	14	1.5
Something needed, but not specified	133	13.9
Nothing needed	19	2.0
Don't know/No answer	484	50.3
Total	960	100.0

Table 3—Kinds of professional people needed to help improve the mental health of the community

	No.	%
Psychologist	7	0.7
Nonpsychiatric physician	295	30.7
Psychiatrist	267	27.7
Nurse	16	1.7
Minister	25	2.6
Guidance counselor	16	1.7
Teacher	17	1.8
Social worker	13	1.4
Other	13	1.4
None needed	14	1.5
Don't know/No answer	277	28.8
Total	960	100.0

operating in the local community has been promulgated as the preferred method for meeting the mental health needs of the community. We were interested in determining the extent to which the communities were aware of this new concept. Less than 1 per cent of our sample had ever heard of the idea; and these few respondents had an understanding of the mental health center program that was superficial, at best. The ten respondents who expressed an awareness of this concept said that they approved of the program and would be willing to pay additional taxes to support it.

Attitudes Toward the Mentally Ill

In order to assess the tolerance of our rural people for someone who had been mentally ill, we incorporated a series of statements ranging from a very close personal relationship (e.g. falling in love) to a somewhat more impersonal contact (e.g. selling a lot to a formerly mentally ill person), and recorded the respondent's reactions to these. These items, as a group, constitute what is termed a "social distance scale," and each respondent can be ranked in terms of the extent he is willing to engage in personal-social relationships with a former mental patient.

Even without using the scaling procedure, we can see a pattern in the responses from our sample. The data show that as the degree of social distance decreases (i.e., the relationship is closer and more personal), the percentage of positive responses to the statements also decreases. For example, 87.7 per cent of the sample said they would be willing to work with someone who had been mentally ill; 71.6 per cent would not mind working in a mental hospital; 66.7 per cent would not hesitate to rent an apartment to a person discharged from a mental hospital; 57.0 per cent would be willing to room with an ex-patient; and, finally, 43.9 per cent could conceive of themselves falling in love with a mentally ill person. The pattern of responses, then, indicates that the majority in the community will tolerate people who have been mentally ill as long as the relationship is not a close one. However, as the relationship becomes more intimate, a decreasing number of the communities' citizens would be willing to interact.

A comparison with the results of the Cumming[8] classic study, *Closed Ranks*, indicates that a larger proportion of respondents in our rural sample would be willing to form a relatively closer personal contact with ex-mental patients than those in the Cumming survey. Examining the three items that represent an intimate relationship, we see that 45.4 per cent of our rural population and 73 per cent of the Cumming sample would discourage their children from marrying anyone who had been mentally ill. In the Blackfoot community (Cumming), only 31.7 per cent could imagine falling in love with a former mental patient while 43.9 per cent in our sample could conceive of doing so. And, finally, 44.4 per cent in the Cumming study and 57.0 per cent in ours expressed a willingness to

room with a person who had been mentally ill.

Attitudes Toward Mental Illness

A majority of citizens in our two rural North Carolina counties, like their urban counterparts in New York City, share the view that "mental illness is the most serious health problem in this country."[9] Similarly, they hold in common the beliefs that "alcoholism is a form of mental illness" and that "mental illness is an illness like any other."

There appears to be very little difference among rural and urban people regarding the treatability of mental illness. An identical number—four out of five—reject the notion that "not much can be done for a mental illness." In our survey, rural people consistently expressed the feeling that a person who becomes mentally ill has an excellent chance for recovery. For example, three-quarters of our sample rejected the idea that "once a person has been mentally ill, he really can never be normal and healthy again." There is also a denial (81 per cent) that little can be done for patients in a mental hospital, and 75 per cent dismiss the notion that "few people who enter hospitals ever leave." Better than three of five (65 per cent) respondents feel that most mental patients will make a good adjustment to the community upon release from the hospital.

Although there may be consensus between rural and urban people regarding an optimistic outlook for the treatment of mental illness, the same is not true for its prevention. In the urban population, nearly nine out of ten (86 per cent) agree that "most people feel very helpless about mental illness." This pessimism is not shared by the rural people in our sample. When asked to respond to the statement, "a lot can be done to prevent mental illness," 87 per cent responded affirmatively.

Lemkau and Crocetti, in their feasibility study of community-based psychiatric emergency and home-care programs, described the general attitude of their urban sample toward the mentally ill as "enlightened."[10] We think that the same description is applicable to the rural people in our two sample counties. When comparing some of the attitudinal items which both studies employed, we note a great deal of similarity in response patterns. Two of the items will, hopefully, suffice to give some idea of the similarities. To the statement, "there are many different kinds of mental illnesses," 92 per cent of the urban and 96 per cent of the rural samples voiced agreement. In the same "enlightened" manner, four out of five respondents in both samples rejected the rather naive perspective that "all people with the same mental illness act in the same way." An examination of these and other responses to attitudinal statements by both rural and urban people furnishes, we believe, additional evidence for our contention that the traditional ways of thinking about mental illness are beginning to diminish as people become better informed about the subject.

Attitudes Toward Mental Hospitals

Not only are we witnessing a trend from "unenlightened" to an "enlightened" outlook toward mental illness, it would also appear that the public's image of mental hospitals has changed dramatically in recent years. No longer does a majority of the public look upon them as "snake pits" or "madhouses." This is not to say that mental hospitals have been accepted on the same basis as general hospitals, but the trend definitely seems to be toward perceiving them as providing better care and more effective treatment for the mentally ill, rather than as a dumping ground for the misfits and social deviants in the community.

Neither is the trend uniform nor do all of the people feel this way. Elinson,

et al., in their survey of mental health services in New York City pointed out . . . "there remains a kind of ambivalence in the public's attitude about the functions of mental hospital services for the mentally ill."[9] They reported that 83 per cent of their sample saw the need for a state mental hospital as serving the function of protecting the community from the mentally ill. On the other hand, the sample felt that conditions are improving and that mental hospitals are, more and more, becoming treatment centers rather than custodial institutions.

The findings of our study confirm the ambivalence which Elinson and his associates have noted regarding the shift toward a more positive view of mental hospitals by the general public. In our survey, a smaller, though still high proportion of respondents (69.0 per cent), stated that mental hospitals are needed in order to protect the community from the mentally ill. At the same time, however, a bare majority (51.4 per cent) denied the notion that every mental hospital should be surrounded by a high fence and guards; and, as many as one in five of our sample agreed with the idea that mental hospitals ought to be set back from the road where they can not be seen easily.

Although these results suggest an ambivalent attitude on the part of rural people, we feel that their total pattern of responses clearly indicates a trend toward a far greater acceptance of the mental hospital as an effective treatment center for the mentally ill.

In further support of the above, we would like to call attention to the fact that more than half of the respondents do not perceive mental hospitals to be similar in nature to prisons. A sizable number of our sample also rejected the propositions that the forms of treatment received in a mental hospital were intended to manage rather than cure the patient (65.8 per cent), and that little could be done for patients except to see that they are comfortable and well fed (80.9 per cent).

Clearly, then, our survey, like many others in the past ten years, provides additional evidence that the public's view about mental hospitals is indeed changing favorably.

Attitudes Toward Psychiatrists

An even more dramatic change seems to be taking place in the popular thinking about the profession of psychiatry. Star, in her paper read to the American Association for Public Opinion Research, reported that her data strongly implied ". . . a quite wide-spread and matter-of-fact acceptance of the existence of the profession of psychiatry . . .," but, she continues ". . . the more noteworthy thing about popular reactions to the profession of psychiatry was a vast indifference, which for all practical purposes constituted rejection."[11] This rejection was, according to Star, based upon unfamiliarity, lack of relevancy, and the relatively little affect generated among most people about the topic of psychiatry.

Space does not permit us to discuss in detail the arguments she puts forth in order to reconcile these seemingly contradictory conclusions. On the basis of the data in our study, we feel that there currently exists an attitude of overwhelming acceptance for the role of psychiatrists among rural people.

Although we will not make the claim that rural people understand exactly what a psychiatrist does or that he must be a licensed medical doctor in order to practice psychiatry, almost nine out of ten respondents are aware that he has something to do with the treatment of mental illness.

As far as his perceived value to the community, 90 per cent expressed the belief that the community would benefit greatly from having a psychiatrist in practice there.

In contrast to the lower class rejection of the psychiatrist in the New Haven community,[12] the responses of our predominantly lower class rural sample displayed convincing evidence that they would encourage their friends to consult a psychiatrist if the need arose. Four out of five respondents said that they themselves would consult a psychiatrist for help with an emotional problem. The appraisal of the effectiveness of the psychiatric treatment a patient receives is positive. Eighty-five per cent felt that most patients feel better after having some kind of treatment.

From time to time it has been suggested that anyone with the time and interest could do the same thing that a psychiatrist does for his patients. This premise is completely rejected by eight out of ten respondents in our study. Apparently they view the role of the psychiatrist as unique—he can do something for the mentally ill that other people cannot do. On the basis of our data, then, we would have to take issue with Star's conclusion ". . . that psychiatrists don't do anything special and (that) anyone can do it."[11]

Perceived Usefulness of Nonpsychiatric Professionals

While the people of our rural sample express an unqualified acceptance of the role of the psychiatrist in the community, they also believe that other physicians, ministers, teachers, and parents have an important function in improving mental health in the community. More than 96 per cent agree that these nonpsychiatric professionals can contribute greatly when they are assisted by mental health experts. Over 90 per cent agree that "the family doctor can help prevent mental illness by helping parents to understand the behavior problems of their children."

In regard to the minister's contribution to mental health, our respondents are somewhat less sure. Forty-eight per cent agree that a person should be able to get help for his emotional problems from his clergyman, but 41 per cent disagree. This contrasts with the findings of the Joint Commission on Mental Illness and Health;[13] of those people who voluntarily sought help, 42 per cent consulted clergymen, 29 per cent physicians in general, and only 18 per cent psychiatrists or psychologists. In our study, in which nearly half expressed favor of the clergyman (a vote of confidence), the psychiatrist is accorded an overwhelming margin in appropriateness.

Teachers also received a split vote. Three out of five of our respondents feel that teachers should be expected to handle the mild emotional problems in the classroom, but only about half the sample feels that the understanding teacher can be as effective with a disturbed child as a special class would be. On the other hand, 70 per cent of our sample agree that it is useful to train teachers to be sensitive to children who have emotional problems.

Parents are endorsed by 88 per cent of our sample as capable of improving the mental health of their children by participating in discussion groups with other parents on child-rearing problems.

Summary

The delivery of mental health services to rural people continues to be a serious problem for mental health program administrators in vast areas of the country. A project designed to develop and assess the feasibility of a particular pattern of rural mental health services has been initiated in two North Carolina counties.

We have reported some of the results of an initial survey of the information, attitudes, and opinions of a representative sample of rural people concerning mental illness, mental health professionals, and program services, which was

done as a first step in assessing a developing rural program. These data represent an addition to the information on urban populations from other studies. Salient findings include the following:

1. Our rural respondents are not aware of even the meager mental health services that exist in the community. They feel that programs for treatment and prevention are needed but they are not sure what they should be. The facility most commonly named as needed is the mental health clinic, and the most needed professional is perceived as the psychiatrist. The comprehensive mental health center concept is practically unknown in this rural sample.

2. The attitudes toward the mentally ill and mental hospitals have clearly changed over the past 20 years. Mental hospitals are seen as treatment centers and not as "snake pits" or places where the mentally ill live out their lives. Some ambivalence toward hospitals continues, however. Our rural sample is more tolerant of the mentally ill today than was an urban sample of the early fifties. Their greater optimism for the mentally ill contrasts with the results of earlier studies and matches that of a recent urban sample.

3. The rural respondents overwhelmingly accept the role of the psychiatrist as unique, both for themselves and family members and friends. This contrasts with earlier studies. In addition, they clearly accept the idea that nonpsychiatric professionals also have a useful role in the mental health effort.

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This paper was presented before the Mental Health Section of the American Public Health Association at the Ninety-Fifth Annual Meeting in Miami Beach, Fla., October 26, 1967.

The research reported in this paper was supported by Grant No. MH O2351-01 from the National Institute of Mental Health.